Chapter 3 Relational Edits 0500-0999 Individual Updates				
Document Version Number	**Revision Date**	**Revision Page Number(s)**	**Reason for Revisions**	**Revisions Completed By**
Version 7.3	September 29, 2006	3-2-84	Update Edit 0646	Anson Haley
Version 7.4	**November 8, 2006**	**Multiple**	**507, 512, 526, 532, 545, 555, 565, 575, 576**	**Anson Haley**

Edit: ESC 0507 The From Date Is After the To Date

Edit 507 revised October 25, 2006

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, B	00	All	Detail	No	Yes	0

Disposition	M, B
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Reject
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit if the to date of service is earlier than the from date of service.

Edit Criteria

If the to date of service is earlier than the from date of service, fail this edit with EOB 0507.

EOB Code

0507 – The from date is after the to date of service – please verify and resubmit.

ARC Code

16 - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.

Remark Code

MA31 - Missing/incomplete/invalid beginning and ending dates of the period billed.

Method of Correction

Claims failing this edit will systematically deny.

Edit: ESC 0512 Claim Past Filing Limit

Note: Edit 0512 revised October 27, 2006

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, O	00	All	Detail	Yes	Yes	0

Disposition	D, H, M, O
Paper Claim	Deny
Paper w/attachment	Suspend
ECS	CCF
Shadow	Pay
POS	Reject
Adjustments	Pay
Special Batch	Suspend

Edit Description

Fail this edit when the days between the last date of service and the ICN date are greater than the filing limit.

Edit Criteria

If the number of days between the last date of service and the ICN date are greater than the one year filing limit, fail this edit with EOB 0512.

EOB Code

0512 – Your claim was filed past the filing time limit without acceptable documentation.

0567 – Your claim was filed past the filing time without acceptable documentation. Please submit your attachments with the *Claim Correction Form.*

ARC Code

29 - The time limit for filing has expired.

Remark Code

N29 - Missing documentation/orders/notes/summary/report/invoice

Method of Correction

Check for keying errors and correct any errors found.

If no errors are found, check for the presence of an acceptable explanation or documentation that would warrant waiving the filing time limitation. If this is present, override the error. Acceptable reasons for late filing are the following:

– Retroactive eligibility – If provider indicates late or retroactive eligibility, a letter from CDPW or SDPW is acceptable. If no confirmation letter is submitted, check the recipient eligibility file. The provider must file the claim within one year of the date the enrollment data was entered.

> *Note: The effective date of enrollment is not reviewed for retroactive enrollment.*

– Previous submissions – The provider should attach evidence of prior claim submission or inquiries. Waive the filing time limit if it can be established that the claim was initially filed within one year of the last service date and refiled within one year of the original or subsequent rejection(s).

– Administrative delay – Waive the filing time limit if the provider submits a letter from the IFSSA or the OMPP confirming the delay in claim filing was caused by State administrative delay(s).

– Late TPL notification – Waive the filing time limit if the provider submits documentation to show he has made reasonable and continuous attempts to bill and collect from an available third party.

– Retroactive PA – Waive the filing time limit if the provider submits documentation proving the delay was caused by retroactive PA approval.

– Appeals – Waive the filing time limit if the provider submits a copy of an appeal ruling that will justify the late filing of the claim.

– Court decisions – Waive the filing time limit if the provider submits a copy of a court order requiring the processing of the claim.

If no explanation or documentation is present, fail this edit with EOB 0512.

First Steps Claims will suspend for Date of Receipt February 1, 2006, through June 30, 2006.

If the DOS on the suspended claim is less than 120 days old, the edit will be Forced

If the Date of Service is 121 days or greater than the Julian Date Review, the Patient Acct field states the following "Filing Waiver" with a date. Email the ICN to the Claims Resolution Unit for instructions on working the claim.

If the date of service is 121 days or greater than the Julian date and the above statement is not in the Patient Account Field, Deny the claim.

This Edit will be set to deny on July 1, 2006.

Edit: ESC 0526 The Statement Covers Period From Date Is After the Through Date

Edit 526 revised October 25, 2006

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, H, I, L	00	All	Header	No	Yes	0

Disposition	A, I, L	H
Paper Claim	Deny	Deny
ECS	Deny	Deny
Shadow	Deny	Deny
POS	Reject	Reject
Adjustments	Suspend	Suspend
Special Batch	Deny	Deny

Edit Description

Fail this edit if the statement covers period through date is earlier than the from date.

Edit Criteria

If the statement covers period through date is earlier than the from date, fail this edit with EOB 0526.

EOB Code

0526 – The statement covers period from date is out of sequence with the through date – please verify and resubmit.

ARC Code

16 - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.

Method of Correction

Claims failing this edit will systematically deny.

Edit: ESC 0532 Revenue Code/Provider Specialty Mismatch

Note: Edit 0532 revised effective October 25, 2006

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	00	All	Detail	No	Yes	0

Disposition	H, I, L, O
Paper Claim	Suspend
ECS	Suspend
Shadow	Deny
POS	N/A
Adjustments	N/A
Special Batch	Suspend

Edit Description

Fail this edit if the billing provider is not approved to bill the revenue code billed on the claim.

Edit Criteria

If a revenue code is billed on the claim, check the reference file to make sure the billing provider's specialty is approved to bill that revenue code. A valid combination should exist in the reference subsystem by verifying the following linkage: Reference/Restriction/Revenue to HCPC. Key in the revenue code in question and if the window reflects that the revenue code billed is valid with the procedure code billed then the claim should be forced to pay. If the revenue/HCPC combination is not valid to bill with the revenue code, fail this edit with EOB 0532.

EOB Code

0532 – Billing provider's specialty is not approved to bill this revenue code – please verify and resubmit.

ARC Code

170 - Payment is denied when performed/billed by this type of provider.

Remark Code

N95 - This provider type/provider specialty may not bill this service.

Method of Correction

Check claim for keying errors and make any applicable corrections.

Check the reference subsystem for a valid revenue to HCPCS combination

If the revenue/HCPC combination is not valid to bill with the revenue code, fail this edit with EOB 0532.

Edit: ESC 0545 Claim Past Filing Limit

Note: Edit 0545 revised October 25, 2006.

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I, L, P, Q	00	All except 590	Header	Yes	Yes	0

Disposition	I	L	P	Q
Other	Inactive	Pay	Inactive	Inactive
Paper w/o attach	Deny	Deny	Deny	Deny
Paper w/attach	Suspend	Suspend	Suspend	Suspend
ECS w/o attach	CCF	CCF	Deny	Deny
ECS w/attach	CCF	CCF	CCF	CCF
Shadow	Deny	Deny	Deny	Deny
Point of Service w/o attach	Reject	Reject	Deny	Deny
Voids/Replacement non-check related	Pay	Pay	Pay	Inactive
Voids/Replacement check related	Pay	Pay	Pay	Inactive
Shadow Replacement	Pay	Pay	Pay	Pay
Shadow Claim Void			Pay	Pay
Mass Replacement Nursing Home	Pay	Pay	Inactive	Inactive
Mass Replacement Financial	Pay	Pay	Pay	Inactive
Elec .Replacement w/attach or clm note	CCF	CCF	Inactive	Inactive
Elec Rplc w/o attach or clm note	CCF	CCF	Inactive	Inactive
Spend-down Mass Rplc	Pay	Pay	Inactive	Inactive
Payer Elec Rplc	CCF	CCF	Inactive	Inactive
Claim Reprocessed by EDS SE	Pay	Pay	Pay	Pay
Special Batch	Suspend	Suspend	Suspend	Suspend

Edit Description

Fail this edit when the days between the service and the ICN date are greater than the filing limit.

Edit Criteria

If the number of days between the last date of service and the ICN date are greater than the one year filing limit and the claim region code equals 10, fail this edit with EOB 0545.

EOB Code

0545 – Your claim was filed past the filing time limit without acceptable documentation.

0568 – Your claim was filed past the filing time without acceptable documentation. Please submit your attachments with the *Claim Correction Form.*

ARC Code

29 – The limit for filing has expired.

Remark Code

N29 – Missing/Incomplete/Invalid documentation.

NCPDP Reject Code

81 – Claim is too old.

Method of Correction

Check for keying errors and correct any errors found.

If no errors are found, check for the presence of an acceptable explanation or documentation that would warrant waiving the filing time limitation.

If no explanation or documentation is present, deny the claim.

If an explanation or documentation is present, supporting one or more of the following, override this edit:

– Retroactive eligibility – If provider indicates late or retroactive eligibility, a letter from CDPW or SDPW is acceptable. If no confirmation letter is submitted, check the recipient eligibility file. The provider must file the claim within one year of the date the enrollment data was entered.

> *Note: The effective date of enrollment is not reviewed for retroactive enrollment.*

– Previous submissions – The provider should attach evidence of prior claim submission or inquiries. Waive the filing time limit if it can be established that the claim was initially filed within one year of the last service date and refiled within one year of the original or subsequent rejection(s).

– Administrative delay – Waive the filing time limit if the provider submits a letter from the IFSSA or the OMPP confirming the delay in claim filing was caused by state administrative delay(s).

– Late TPL notification – Waive the filing time limit if the provider submits documentation to show he has made reasonable and continuous attempts to bill and collect from an available third party.

– Retroactive PA – Waive the filing time limit if the provider submits documentation proving the delay was caused by retroactive PA approval.

– Appeals – Waive the filing time limit if the provider submits a copy of an appeal ruling that will justify the late filing of the claim.

– Court decisions – Waive the filing time limit if the provider submits a copy of a court order requiring the processing of the claim.

– A screen print of the Provider Electronic Solutions software is acceptable documentation for waiving the filing limit, if filed within the one-year time frame. The third box that has claim status information is where the finalized date can be obtained. This is effective January 4, 2002.

Effective December 6, 2002, when processing claims for any attachment edits, see if there is an attachment from Medicare or other insurance. Check the claim and supporting documentation for mismatched procedure codes. Because of I letter 20010321, from the OMPP, it is imperative claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The following codes can be switched between Medicare and Medicaid: G codes, anesthesia codes billed to Medicare with 00***, and A0425. If the codes are switched or mismatched the claim will be denied with EOB *2508-Your service has been denied.* The code billed to Medicaid was not the code billed to the primary insurer.

Edit: ESC 0555 Units Billed Does Not Equal the Date Span

Note: Edit 0555 revised effective October 25, 2006

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	00	All	Detail	No	No	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	N/A
POS	N/A
Adjustments	Deny
Special Batch	Deny

Edit Description

Fail this edit when the units billed with modifier 55 are greater than or less than the span of time indicated by the dates of service billed.

Edit Criteria

If the units billed are greater than or less than the span of time indicated by the dates of service billed procedure codes billed with modifier 55, then fail this edit with EOB 0555.

EOB Code

0555 – The units billed must equal the number of days indicated by the dates of service billed.

ARC Code

125 - Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.

Remark Code

M53 – Missing, incomplete, or invalid days or units of service.

Method of Correction

Claims failing this edit will systematically deny.

Edit: ESC 0565 Paid Amount Greater Than the Billed Amount

Note: Edit 0565 revised effective October 25, 2006

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, P, Q	00	All	Header	Yes	No	0

Disposition	D, H, M, P, Q
Paper Claim	Suspend
ECS	N/A
Shadow	N/A
POS	N/A
Adjustments	N/A
Special Batch	N/A

Edit Description

Fail this edit when the total reimbursed amount is greater than the header billed amount.

Edit Criteria

If the total reimbursed amount is greater than the header billed amount, fail this edit with EOB 565.

EOB Code

0562 – Hospice services have incompatible type of bill and revenue codes being billed.

ARC Code

0565 - Paid amount is greater than billed amount.

Remark Code

172 - Payment is adjusted when performed/billed by a provider of this specialty.

Method of Correction

Check for keying errors in billed amount and units and correct any errors found.

If no keying errors, force edit.

Edit: ESC 0575 Fifteenth Diagnosis Code Invalid Format (Header)

Note: Edit 0575 New effective October 25, 2006

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	**00**	**All except MRT and PASRR**	**Header**	**No**	**Yes**	**0**

Disposition	H, I, L, O
Other	**Deny**
Paper w/o attach	**Deny**
Paper w/attach	**Deny**
ECS w/o attach	**Deny**
ECS w/attach	**Deny**
Shadow	**Deny**
Point of Service w/o attach	**Reject**
Point of Service w/attach	**Reject**
Voids/Rplc non-check related	**Inactive**
Voids/Rplc check related	**Inactive**
Shadow Rplc	**Deny**
Mass Rplc Nursing Home	**Inactive**
Mass Rplc Financial	**Inactive**
Mass Rplc Reprocess by EDS SE	**Inactive**
Elec Rplc w/attach or clm note	**Deny**
Elec Rplc w/o attach or clm note	**Deny**
Spend-down Mass Rplc	**Inactive**
Payer Elec Rplc	**Deny**

Edit Description

Fail this edit if the fifteenth diagnosis code is not a valid format.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

Edit Criteria

If the fifteenth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 0575.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

EOB Code

0575 – The fifteenth diagnosis code is not in the correct format – please verify and resubmit.

ARC Code

47 – This diagnosis is not covered, missing, or are invalid.

D21 – This (these) diagnosis(es) are missing or are invalid.

Remark Code

MA64 – Missing, incomplete, or invalid other diagnosis.

Method of Correction

Claims failing this edit will be systematically denied.

Edit: ESC 0576 Sixteenth Diagnosis Code Invalid Format (Header)

Note: Edit 0576 New effective October 25, 2006

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	**00**	**All except MRT and PASRR**	**Header**	**No**	**Yes**	**0**

Disposition	H, I, L, O
Other	**Deny**
Paper w/o attach	**Deny**
Paper w/attach	**Deny**
ECS w/o attach	**Deny**
ECS w/attach	**Deny**
Shadow	**Deny**
Point of Service w/o attach	**Reject**
Point of Service w/attach	**Reject**
Voids/Rplc non-check related	**Inactive**
Voids/Rplc check related	**Inactive**
Shadow Rplc	**Deny**
Mass Rplc Nursing Home	**Inactive**
Mass Rplc Financial	**Inactive**
Mass Rplc Reprocess by EDS SE	**Inactive**
Elec Rplc w/attach or clm note	**Deny**
Elec Rplc w/o attach or clm note	**Deny**
Spend-down Mass Rplc	**Inactive**
Payer Elec Rplc	**Deny**

Edit Description

Fail this edit if the sixteenth diagnosis code is not a valid format.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

Edit Criteria

If the sixteenth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 0576.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

EOB Code

0576 – The sixteenth diagnosis code is not in the correct format – please verify and resubmit.

ARC Code

47 – This diagnosis is not covered, missing, or are invalid.

D21 – This (these) diagnosis(es) are missing or are invalid.

Remark Code

MA64 – Missing, incomplete, or invalid other diagnosis.

Method of Correction

Claims failing this edit will be systematically denied.